Karnataka Jnana Ayoga:

Mission Group on Public Health

Meeting – II

Date: 26th May 2012(Saturday)

Venue:

Vikasa Soudha, Bangalore.

Time:

10:30am -5:00pm

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Agenda:

Time	Topic	Presenter
10:30 -11: 00am	Introduction of agenda	Dr.Ravi Narayan
Updates by mission group members		
Chairperson: Smt.Sita Lakshmi Chinnappa		
11:00 – 11:20 am	Introduction to Karnataka GIS	Prof. Mukunda Rao
11:20-11:30 am	Discussion on some steps towards health GIS	
11:30-11:50am	Overview of HRD including Public health cadre and Public health capacity building*	Dr.N Devadasan ,IPH, Bangalore.
11:50- 12:00 am	Discussant: Dr. G. Gururaj	
12:00- 12:30am	Next steps on HRD (MGPH) after remarks by HS/HC/Dir. NRHM	
Chairperson: Dr. Ravi Narayan		
12:30- 12:45 pm	Jana Oushadhi Scheme for Karnataka*	Dr.Gopal Dabde, DAFK /JAAK
12:45-1:00 pm	Discussion on next steps on the scheme (MGPH)	
1:00- 1:15 pm	The malnutrition challenge-beyond existing response*	Dr.Gopal Dabde, DAFK /JAAK/
1:15-1:30 pm	Discussion on next steps in tackling malnutrition challenge (MGPH)	
1:30-2:15 pm	**LUNCH BREAK-**	
Chairperson: Smt.Sita Lakshmi Chinnappa		
2:15-2:45 pm	AYUSH and Public Health : innovation schemes • Generating clinical evidence about Ayurveda practice* • The program of Certification & Accreditation of Folk Healers as Community Health Workers* • Promoting copper as water purifier*	Sri Darshan Shankar I-AIM.
2:45-3:15 pm	Discussion on next steps in promoting schemes (MGPH)	
3:15-3:30 pm	Urban primary health care and women health	Dr. Ruth Manorama, NAWO
3:30-3:45 pm	Discussion on next steps (MGPH)	
Chairperson: Dr.Ravi Narayan		
3:45-4:00 pm	AYUSH system innovations (Recommendations to KJA)	Dr. R.Kishore Kumar, NADRI
4:00-4:15 pm	Discussion on next steps (MGPH) after comments by Director AYUSH.	
4:15-5:00 pm	Chairperson : Prof. M.K.Sridhar (?) Next steps for MGPH. 1. What else do we want to discuss next 2. Stake holder workshops for June/July ?? a) Jana Oushadi Scheme (Dharwad) b) Public Health Capacity Building. (Bangalore) c) Action for Nutrition (Mysore) 3. Public health charter- next steps 4. Review studies of KJA Health Fellows 5. Some small studies. (regional disparities, health budget review) 6. Any other suggestions.	

Back ground papers for the meeting. (Shown with * against each agenda item)

1. Public health cadre and Public health capacity building
    a. Human Resource development and Human Resource management- KJA Note.
    b. Creation of Public Health Cadre, KJA Note.
    c. Report of committee for creation of Public Health Cadre, and reorganization of the Department of the Health and Family Welfare Services.
    d. Budgetary proposal-3: State School of Public Health- KJA note.
2. Jana Oushadhi Scheme for Karnataka
    a. Documentation on Rajasthan Jan Aushadhi model in Rajasthan, by Dr. Samit Sharma, Collector & District Magistrate Chittorgarh (Rajasthan)
    b. Report of the seminar on Models and methods for ensuring availability of essential medicines in public health facilities, SATHI, 24th June, 2011. (From Dr. Narendra Gupta, PRAYAS, Rajasthan)
3. Malnutrition Challenge-Beyond Existing Response
    a. Community Action For Nutrition Note for the AGCA-NRHM-23rd January 2009 (From Dr. Thelma Narayan, SOCHARA)
    b. Recommendations to the Malnutrition Monitoring Committee, (Submitted by Jana Arogya Andolana - Karnataka,17th May, 2012)
4. *Urban Primary health care and Womens Health – A note from Ruth (awaited)*
5. AYUSH and Public Health System: Innovative Schemes (from Darshan)
    a. Generating clinical evidence about Ayurveda practice
    b. The program of Certification & Accreditation of Folk Healers as Community Health Workers (not licensed doctors)
    c. India's Cheapest Solution for Microbial Purification of Drinking Water, (From Dr. Padma Venkat - I-AIM)
6. AYUSH system innovations-Recommendations to KJA. *(Kishore)*
7. Draft Charter on Public Health for the state of Karnataka-updated with comments of Darshan and Bala.
8. Note on Palliative care- (From Dr. R. Bala)

Karnataka Jnana Aayoga
(Karnataka Knowledge Commission)
Government of Karnataka

Minutes of the First Meeting of Mission Group on Public Health
April 19, 2012, 2.00 PM at Room No. 222, II Floor, Vikasa Soudha, Bangalore

I. Members:

1. Sri. E. V. Ramana Reddy, Secretary, Dept. of HFWs, GoK
2. Dr. Ravi Narayan, Chairman, MGPH and Member, KJA
3. Smt. Sita Lakshmi Chinnappa, Co-Chairman, MGPH and Member, KJA
4. Sri. Darshan Shankar, Member, MGPH
5. Dr. R. Balasubramaniam, Member, MGPH
6. Dr. G. Gururaj, Member, MGPH
7. Dr. Gopla Dabade, Member, MGPH
8. Dr. Ruth Manorama, Member, MGPH
9. Dr. G. N. Sreekantaiah, Director, Dept. of AYUSH, GoK
10. Dr. R. Kishore Kumar, Member, MGPH
11. Prof. M K Sridhar, MS & ED, KJA
12. Smt. Jayashri, RA, KJA

II. Agenda

To seek views and opinions of the members with regard to the issues to be taken up by the MGPH

III. Deliberations

Prof. M. K. Sridhar welcomed all the Members and briefed on the activities of KJA. He also mentioned that KJA is having very good rapport with the Departments - Health and Family Welfare Services and Primary and Secondary Education with regard to implementation of KJA recommendations. , He requested the members of the Mission Group to introduce themselves briefly and share about their initiatives in their respective fields.

The Health Secretary shared that the MGPH has to concentrate on the HR issues of the Dept, since this is a continuing challenge He requested it as a priority area under the Mission Group and welcomed recommendations to the Dept. He requested that , the Commissioner, DHFWs and Mission Director, NRHM could be invited to the forth coming MGPH meeting as invitees to maintain continuity in our discussions with the department

Dr. Ravi Narayan welcomed the members and requested them to participate in the brainstorm session of MGPH. He outlined the perspectives of the KJA and presented some

tasks for the MGPH to consider drawing on the earlier phase of the KJA and other policy initiatives **(see Annexure I)**. He also appealed to the members to give their opinions and suggestions on priority themes for the MGPH to consider. .

IV. Brainstorming Session

Sri. Darshan Shankar outlined the following:

1. Dept. of AYUSH, GOI, QCI and IGNOU have launched a pilot project of certifying and accrediting of Traditional Health Practitioners to ensure acceptability and standards. The same planned method could be adopted by the GoK, as a pilot demonstration in the state and this could be anchored by the Dept. of AYUSh and local University.
2. In the light of the continuing challenge of providing safe water supply at house hold level, dissemination of information like using a copper vessel to reduce microbial contamination/chemical contamination in drinking water needs to be propagated as a campaign. Apart from being a cheaper method compared to existing alternatives this initiatives would also symbolize an example of validated traditional knowledge and practice being put to contemporary use. .
3. There is inadequate medical evidence/transdisciplinary evidence with regard to the efficacy of Ayurvedic solutions. Ayurvedic medicines cannot just be evaluated by the standard method of double blind controlled clinical trials. Hence there is urgent need to develop a software and documentation formats in collaboration with III-T and to collect data and collate these solutions from AYUSH hospitals and practioners to whom this could be given at free of cost. .

Sri. Sreekantaiah completely endorsed the points raised by Sri. Darshan Shankar and suggested the following additional ideas

1. Planning a 1 ½ year of integrative short-term course/training on modern medicine to the AYUSH doctors of the State to create plural practioners
2. Greater Impetus on preventive health care (Swasthya Vritta) based on evaluated experience of the ongoing multidistrict program.
3. Intensive yoga awareness and training programmes in schools and health centres
4. Opening of AYUSH dispensaries in all hobli centres and taluka HQ.
5. Short term public health training for AYUSH doctors already posted in collocated PHC's and in AYUSH hospitals and dispensaries. This has already been discussed with SOCHARA and other organizations recently.

Sri. Kishore Kumar broadly briefed on the mapping of traditional dietary practices undertaken by his institutions. He suggested that focus on non-communicable diseases, lifestyle and dietary practices of public would be a priority He also opined that there was an

important challenge of increasing substance abuse in rural areas which could be addressed through AYUSH systems. He stressed also the need for empowering AYUSH practitioners to undertake AYUSH research studies.

Sri. Bala Subramaniam emphasized the need for focus on actionable items which could be converted into recommendations of the MGPH. He focused on policy action in the area of governance including accountability and communitization. He suggested that the following policy action is urgently required:

1. Officers of the respective departments to be made accountable for delays and other problems
2. Users and providers of health information must have access to more information and the asymmetry of information available to providers and users must be tackled.

Dr. Gopal Dabade suggested that the following issued should be considered

1. Standard treatement and clinical guidelines for AYUSH drugs
2. Policy action against increasing privatization of health care
3. Urgent policy action on the nutrition status of children and women in the state
4. The challenge of privatization of water and its effects on access of water to the poor and marginalized especially in urban slums.
5. Increasingly availabilty of information on the health and related ministry websites
6. The Jana Oushadhi program based on the recent Rajasthan state experience.

Dr. Gururaj suggested o focus on 5-6 areas/issues in the area of public health to strengthen the following aspects : i.e. governance, public health cadre, Human Resource Development especially the current challenge of less basic doctors and more specialist ; and commercialization of health care etc. All Health programs of the State have to be monitored and evaluated to test the efficacy of these programs, particularly many new ones which are in the PPP mode or have been outsourced to other groups by the government.

Dr. Ruth Monorama emphazied the need for a broader mandate to strengthen women's health which should include violence against to women as a public health issue. Focus on women health, could also increase health awareness, and access, Yoga training, address malnourishment, and deal with mental stress and health which are the great need of the hour especially for women in Urban slums.

Dr. Ravi Narayan presented some evolving ideas for MGPH drawn from earlier reports and discussions. These included : s**trengthening Public Health capacity in the state; enhancing**

and increasing efforts to strengthen AYUSH and main stream with Public health systems in the state; designing and launching healthy life style policy for youth as part of youth policy of the state; strengthening essential drug program in Primary Health Care System keeping goals of UHC in mind; designing and strengthening campaigns for ensuring access, equity and empowerment for two major determinants of health; a) Tackling malnutrition b) Adequate provision of water and sanitation (include Zero manual scavenging) ; strengthening HMIS in the state including E-governance and GIS; enhancing decentralized planning and responding to regional inequalities in health including strengthening district planning and enhancing knowledge translation in health for community empowerment including health website and a health Wikipedia. (see annexure 1)

He also said that, we could invite Mr. Mukund Rao, Chairman, Task Force on K-GIS to brief on the GIS applications and how health sector could be bought under GIS.

The brain stroming led to a very large list of relevant ideas for which the next step would be a priority setting exercise.

V. Decisions taken

1. It was decided to have meetings of MGPH on every fourth Saturday of the month.
2. Members of MGPH were requested to select 2-3 areas from this longer list of suggestions and send further details for focused action including references. This could be sent to the Chairs and convenor of the MGPH who would circulate and plan the next meeting. (which is now scheduled for 26th May 2012)

The meeting ended with Vote of Thanks at 5.45 PM

AN EVOLVING PUBLIC HEALTH CHARTER FOR STATE OF KARNATAKA (incorporating ideas suggested by MGPH Members)

1. **Public Health in Karnataka – Overview and Key challenges (Ravi)**
   Including HRD, privatization and commercialization, accountability and governance, communitisation ; emerging health problems and challenges

2. **Public Health – Capacity building**
   a) Public Health Cadre (Gururaj to summarize and critique the expert group report on Public Health Cadre for Karnataka)
   b) HRD unit in Health Department - MGPH members to comment on note prepared by KJA earlier (Jayashri)
   c) State School of Public Health -MGPH members to comment on note prepared earlier (Ravi /Deva)

3. **Public Health – Governance**
   a) Accountability and Transparency (Bala)
   b) Governance including decentralization (Bala)
   c) Communitisation including PRI (Bala)
   d) Review of PPP- system based on monitoring /evaluation and evidence of these systems (Gururaj)

4. **Public Health – Inter-sectoral challenges**
   a) Tackling malnutrition challenge in state (Gopal)
      - Child malnutrition
      - Anemia in adolescents/women
   b) Promoting safe water supply initiatives
      - Tackling privatization of water. (Bala)
      - Promoting appropriate technology for water purification eg copper (Darshan)
   c) Promoting Sanitation Campaigns (
      - Total sanitation Abhiyan /Nirmal gram in state (Ravi)
      - Campaign for no manual scavenging in state (Ruth)
      - Health of Pourakarmikas (Ruth)
      -

5. **Public health – System response other than HRD**
   a) Essential Drugs for Primary Health Care - Emulating Jana Oushadhi programme of Rajasthan Government (Gopal)
   b) Healthy life style promotion in youth policy of state (Gururaj)
   c) Tackling health challenges of women included violence particularly in Urban areas. (Ruth)
   d) Tackling substance abuse in Rural areas (Kishore)

6. **Public Health – Promoting pluralism and Integration**.
   a) Strengthening documentation of clinical outcomes in AYUSH sector on a standardized and large scale (Darshan)

b) NCD's and Dietary practices – evolve a campaign using traditional knowledge and practice (Kishore)

c) Accreditation /Registration of local healers and practitioners with the help of IGNOU or state University along UN suggested process - collaboration with Mission Group on Traditional /Community Knowledge Systems (Darshan/Hari)

d) Public Health Orientation and Training of all AYUSH Health Personal – starting with government sector (Sreekantiah / Kishore)

e) Strengthen Swasthya Vritta Programme presently experimented with in five districts (Sreekantiah/Kishore)

f) Strengthening Yoga awareness and skills through Health Promotion in curriculum at School of college level (Kishore)

7. **Public health – Strengthening HMIS and Knowledge translation**.

(i) Health Information tackling access / asymmetry between information available to providers and users (Bala/Gopal)

(ii) Health and e governance (Ravi)

(iii) Health and GIS – collaboration with GIS task force (Ravi)

The goal of Human Resource Development (HRD) policy is to ensure availability of suitably qualified, appropriately skilled and motivated human resources for health at appropriate geographic level of pre-defined disciplines. Improved decisions require up-to-date and detailed information about three components of human resource for health: (a) The workforce (b) The work performed (c) The work settings. Strong leadership and management skills are crucial to finding solutions to the human resource crisis in health.

Way of looking at Human Resource Development can be from its scope in terms of strategic and tactical perspective. Under Strategic perspective – Organization Planning, Manpower Planning and Career Planning while under Tactical perspective – organization's and individual performances set the scope of annual activities under HRD.

a. HRD and its relevance to Medical Professionals:

Many medical professionals perceive HRD as the responsibility of Personnel department located at the head quarters and this results in shifting of responsibilities to wrong people. The responsibility of the professional in the field is much more towards the manpower placed in his hands and ultimately the individual himself has to take interest in his own development. The HRD department can function mainly as a facilitating department and support the organization in developing the HR policies, HRD Instruments and processes and facilitate course ware (instruction manuals) development.

Sub systems of HRD :

The major sub systems that most of the HRD departments adopt to fulfil their obligations towards developing organization and the people are:

i. Organization planning and structuring, Manpower planning

ii. Role analysis and development

iii. Attitude survey (Organizational climate survey)

iv. Induction

v. Performance (work) planning, Analysis and review

vi. Performance counseling

vii. Training and Education

viii. Potential Appraisal

ix. Team Building

x. Career planning and development

xi. Succession planning

xii. Job rotation (Transfers)

xiii. Professional Networks – Learning Networks

xiv. Mentorship

xv. Stress Audit and Management

The immediate actions recommended are:

- Establish Human Resource Development Department within the broad frame work of Administrative Office at the Health & Family Welfare Dept.

- Carry out perspective planning for the Human Resource required to meet current and future demands placing special emphasis on Specialists, Nurses and Pharmacists required to render effective health care.

- Establish role clarity of all individual personnel, which eliminates duplication of roles and drives accountability.

- Introduce systematic Induction programme.

- Develop goal based open performance appraisal system involving self-appraisal, superior appraisal and review appraisal with dialogue between the subordinate and superior.

- Set up a system of periodic training including management training based on the immediate and long term deliverables of the health department, performance gaps in the individuals and growth ladder of the individuals' careers. This shall aim to address the skill levels required at different rungs of the organisation ladder. The training shall aim at certifying medical personnel for the different roles that they need to play as members of community health practitioners or Hospital management personnel. To facilitate this, all training establishments such as SIHFW, District Training Centres and the

HRD cell shall function in a coordinated way and supplement each other's activity ensuring elimination of duplication.

- The medical education shall respond to the emerging and current needs of the health services. To fulfil its obligation, a shorter Medical Education programme titled B.R.M.S of three and a half years duration with one year internship needs to be introduced. This will address the endemic shortfall of personnel of MBBS qualification at PHCs.

- Adopt e-HRM software package for administering all transfers. This shall ensure that all posts are filled only with people of prescribed qualification, experience and skill levels.

- Establish communication programme for Health Workers through suitable media.

a. Purpose of HRD office:

i. To address the terms and conditions of employment for all staff.

ii. To establish and maintain a fair and equitable compensation system.

iii. To promote performance planning and review as a joint process between supervisors and employees.

iv. To develop training strategy directly linked to the goals of the organization.

v. To develop resources for meeting the future staffing needs of the organization.

vi. To maintain up-to-date employee data systems and personnel files.

vii. To assist in developing a professionally stimulating, stable and supportive working environment.

viii. To define and support practices which foster trust and respect between all levels of individuals in the organization.

HRM Staff Position Descriptions:

The following position descriptions can provide guidance on developing the roles and responsibilities for staffing an HRM office.

i. Asst. Director - HRM - Overall responsibility for HRM activities and directly supervise transfers, promotions and disciplinary proceedings adhering to the prescribed policies. He shall report to commissioner of H&FW.

ii. Recruitment Officer

iii. Benefits Manager to oversee compensation mgt, rewards and incentives as prescribed by the policies.

iv. Training Manager

v. Personnel Assistant

b. Induction:

The Induction serves to introduce people to the rules and regulations of the workday and also other staff members. It also serves the essential requirement of acculturation of the individual to the health department and his role in the larger context of meeting the objectives of health governance.

i. Prepare induction packet or personnel manual.

ii. Make sure the new staff member has a place to work and the necessary supplies.

iii. Schedule necessary in-house meetings to link employee with other staff relevant to their job.

iv. Clearly explain the mission, goals and objectives of the program.

v. Explain the structure of the organization and the lines of authority.

vi. Provide any training necessary.

vii. Arrange a trip, if necessary, so that all off-site staff have opportunity to be included.

viii. Set clear performance objectives and tasks for the first 3 months of work.

c. Performance Appraisal (Work, Planning and Review) :

With careful planning and implementation, a Performance Planning and Review (PP&R) system provides the organization with :

i. Systematic Performance Planning

ii. Systematic Performance Review

iii. Objective Information : PP&R process will guide management decisions on salary and merit awards, promotions, transfers, work assignments and staff development needs.

The Performance Planning and Review process is a collaborative effort between two people. The major steps in the process are as follows:

i. Work Planning : Job Objectives and activities for the future course

ii. Performance Review : Performance Objectives and Performance Standards

iii. Performance Planning : Performance standards and goals (quantity, quality, and timeliness), Training and resource needs.

A PP&R system requires that department has a standard form to be used as applicable to different levels of staff. The form shall be used to document the performance planning and review meetings and should have standard information and must be developed on the basis of needs of the department and the ability to implement objectively.

d. Training and Education :

i. Linking Training and Education of personnel to the department goals and individual career growth objectives is necessary.

ii. The next step is developing the necessary curriculum and trained / experienced faculty to teach.

iii. Involving professionals' from the field and supervisors with back up support of course-ware and training methodology.

iv. Providing pedagogic skills to all professionals and supervisors since they have to be involved in delivering the training content to the participants.

v. Attention to be paid to the evaluation of effectiveness of training.

Goals of Training Plan:

Prioritise goals, training activities and the employee target groups, plan for resources needed to support the career development needs of employees.

Assess:

i. Finalise the goals and rank in priority order.

ii. Assess the knowledge, skills and abilities of the existing staff.

iii. Develop a needs assessment process and train according to the needs of staff.

iv. Develop staff capacity to meet the department goals and accordingly develop a training plan.

v. Assessment of necessary resources and revenues.

Training cost:

Cost may include - Contracted and external trainers, Honoraria for resource persons, training course ware development, food / lodging, transportation for participants and resource persons, audio visual aids and miscellaneous.

Creation of Public Health Cadre

Implementing Agency: Department of Health and Family Welfare Services

Objectives:

- To bring about a qualitative improvement in the deliverables of Public Health.
- Revive and recognize the emphasis on Public Health services.
- To create an ambience to stay at the designated Primary Health Centres.
- To increase the exposure during their under graduation to rural health services.
- To promote grade system and change of stations.
- To attract competent and committed doctors for the rural health services.
- Reorganization of the divisions on the basis of integrated responsibilities and current needs.

Need

Public health practice has been defined as ***the science and art of disease prevention, prolonging life, and promoting health and well-being through organized community effort for the sanitation of the environment, the control of communicable infections, the organization of medical and nursing services for the early diagnosis and prevention of disease, the education of the individual in personal health and the development of the social machinery to assure everyone a standard of living adequate for the maintenance or improvement of health.*** A successful public health system focuses on prevention and health promotion rather than the cure and treatment.

Public health systems throughout the developing world are consistently involved in improving health services. In spite of the vastly improved technology and communication facilities, delivery of health care by these systems remains a labor-intensive process. Hence, manpower remains a critical component.

At the time of independence in 1947, the fledging medical and public health were separate cadres, each with its separate career ladder. Following the 1946 Bhore Committee report, the two services were unified in the Central Government and the states were instructed to follow suit. Over time, attention and resources gravitated towards medical services and led to the atrophying of the public health component. With about 8143 Sub-centres (SC), 2195 Primary Health Centres (PHCs) and 323 Community Health Centres (CHCs), the healthcare system in Karnataka has been designated acceptable national norms. There are 54 fully functional First

Referral Units (FRUs). Unlike other states, Karnataka also has an additional health mechanism at the village level called Primary Health Unit (PHU) that offers services of a Medical Officer, along with paramedical and non-paramedical staff.

At the State, the problem is the chronic shortage of human resources in the so called backward areas/northern districts. Most very often they do not stay at the designated PHCs; they want to be in urban areas. They have had little exposure during their under graduation to rural health services and poorly sensitized about the health needs of people in rural areas. There is a need to develop public health administrators with expertise in related areas of community health including disease characteristics, their prevention and control, management in crisis situations, forecast strategic disease prevention policies, quality assurance and regulatory affairs.

As per the Calcutta Declaration on Public Health (December 1999), there is a need to promote public health as a discipline, to recognize the leadership role of public health in formulating and implementing public policies, to create a supportive environment and enhancing social responsibility and to advocate increased allocation of human and financial resources for health to strengthen and reform public health education, training and research. ***The current structure of health services in the state has evolved over the years. It has been moulded by the differing emphasis on preventive and curative aspects of healthcare at different points of time. The focus on curative care and immunization has eroded the public health (preventive) element in the approach towards health services.***

The State cadre and Recruitment Rules adopted since 1994 also did not accord any preference for public health professionals in the health department, resulting in dependence on clinical professional to design and deliver public health services in the State. The limited focus on important aspects of preventive healthcare including epidemiology, demography, disease surveillance, health research, environmental sanitation and health program management has adversely impacted the delivery of public health services. It is critical to have a cadre of Public Health managers, with adequate knowledge and education and practice to take the charge of management, supplies and services, equipment and drugs, administration etc., thus leaving the clinically qualified doctors to discharge their clinical duties more effectively.

The current structure of health services has evolved over the years, with differing emphasis on the preventive and curative aspects at various points of time. There is a need for the reinstitution of a strong public health element in health services.

The Indian Public Health Association (IPHA) believes a separate cadre of Public Health managers may be the most appropriate option to address some of the issues raised above.

The proposed cadre should have:

1. Rational cadre structure – need based and scientifically formulated.
2. A well defined recruitment policy to attract young and talented medical professionals.
3. A rational promotion policy to motivate the officers.
4. Encouragement and incentives for higher education and training in public health related courses.

As per the recommendation of Task Force on Health and Family Welfare, Government of Karnataka (2001) two separate cadres for Public Health (Preventive) and Medical (Curative) has to be created under the Department of Health and Family Welfare. It is critical to have a cadre of Public Health Managers, with adequate knowledge and education and practice in public health to take charge of management, supplies and services, equipment and drugs, staff administration etc., thus leaving the clinically qualified doctors to discharge their clinical duties more effectively.

Need for Public Health Professionals

One must address the capacity gap among health personnel. There is a severe shortage of trained public health professionals with an understanding of the principles and practice of Public health services including broad based multi-disciplinary knowledge of the determinants of health. There is need of public health professionals equipped with technical expertise and managerial skills to design and deliver health programs from the State level down to the village level.

Sector	Need	Current Status for Public health system
In Govt.	Public Health Professionals **(Approx) 8630 ***	• Quality of training currently provided inadequate. • Vital need for quality of Public Health Training in govt. machinery.

*: Statistics by Karnataka Development Program, January 2010

Policy elements

The existing Department of Health and Family Welfare services needs to be re-designated as the Department of Public Health and Medical Services and it can have two wings: one related to Public Health and the other related to Medical Services. The Task Force report draws the following main elements of the re-designated structure:

1. The common direct recruitment point would be at the level of PHC doctor. While the basic qualification would be MBBS, those with Post graduate qualifications would also be eligible to be selected.

2. All newly recruited doctors would serve a minimum period (3 years – 5years) in the PHC.

3. After this minimum period of service in the PHC:

   - Those with Medical (Clinical) PG qualifications would be assigned to the Medical cadre.

   - Those with Public Health qualifications would be assigned to the Public Health cadre.

   - Those without PG qualification may opt for either cadre, subject to acquiring the PG qualification necessary for that cadre within a stipulated period. The State would meet the costs for acquiring this qualification only for the first attempt and only for one subject.

   - Those without a PG qualification and who do not wish to acquire these would continue as PHC doctors permanently.

4. Vacancies in the posts of MO (PHC) could be filled by temporary appointments, till such time a direct recruitment is made.

5. Vacancies in the posts/cadres above the level of the MO (PHC) which cannot be filled by the promotion due to non-availability of suitable officers with PG qualifications could be filled by appointment of persons on a temporary contract basis. Such persons would have to satisfy the stipulated conditions with regard to qualification. Such appointment would be till such time as suitable internal candidates become available.

6. The choice of PG courses would be guided by the needs of the department and not based on personal preferences of the officer.

7. Promotions would therefore be within the cadre and no interchange across the cadres would be permitted.

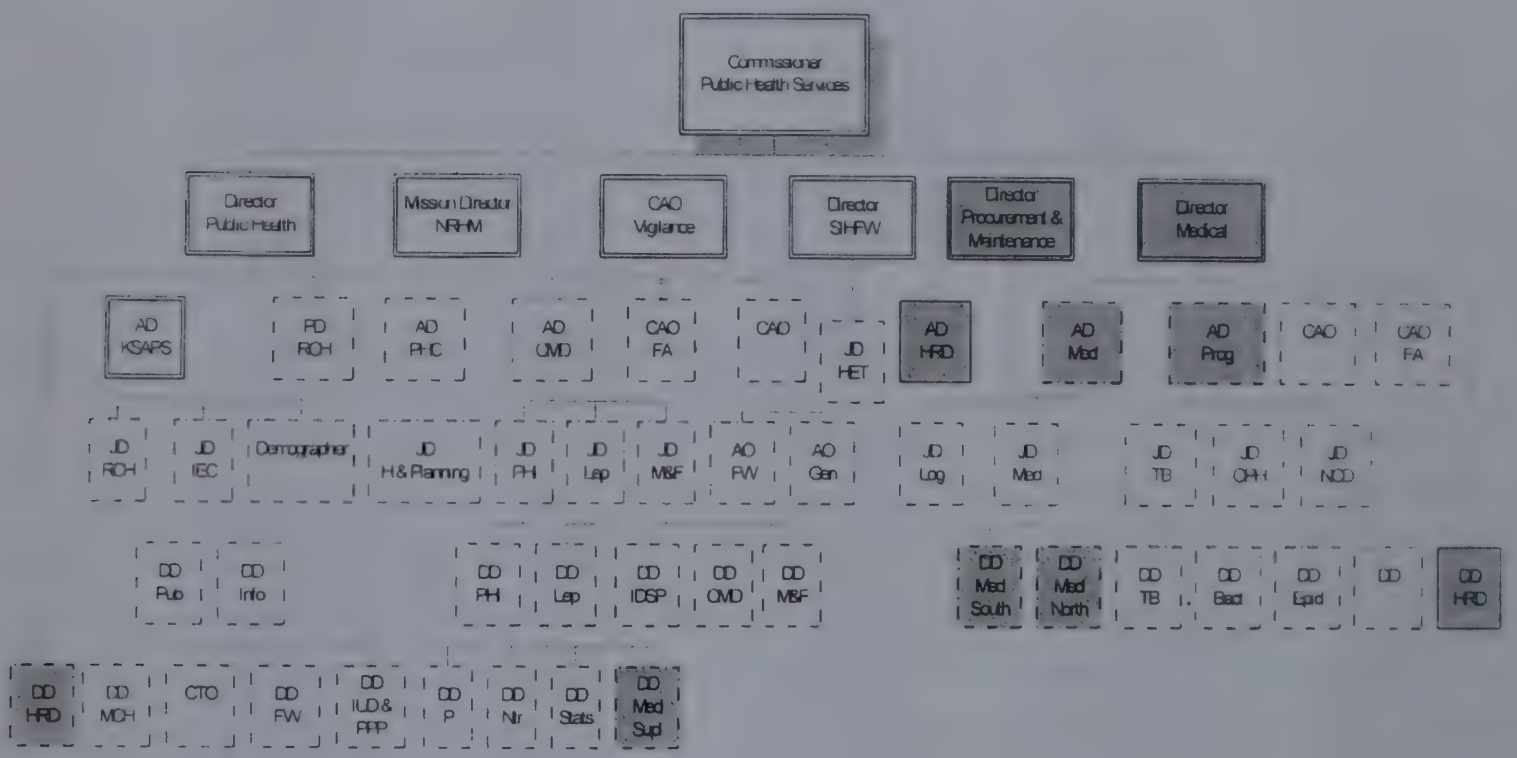
8. The Public Health and Medical Services wing would consist of divisions based on current needs and each of these wings would be headed by a Director.

9. The overall management of the Department could be by the Commissioner or Director General of Public Health and Medical Services.

The cadre system would contribute to morale building and create a sense of common identity. The major advantage of constituting such a system would be that young professional would, through a process of selection, rise to occupy middle level management position fairly early, so that stability in management is ensured at higher levels.

Proposed Organizational Structure at the State

The following is the proposed structure for the Department of Public Health and Medical Services in line with the recommended structure in the 2001 Task Force report.



Source: Draft Action Plan, Human Development Mission Group, Planning Department, GoK.

Note: The shaded boxes represent the new positions proposed. Most of the restructuring is possible by rearranging the existing posts under appropriate divisions.

Commissioner/Director General of Public Health and Medical Services

The Directorate of Public Health and Medical Services will be headed by Commissioner, who will report to the Secretary/Principal Secretary. The main function of the Commissioner would be to bring about better internal and inter-sector co-ordination and to achieve a greater degree of accountability in Health and Medical services both in financial and administrative terms. The Key activities to be performed by the person holding this post could be:

1. Monitoring, supervising and implementing all national and state health and family welfare programs in the State.

2. Ensuring co-ordination among various directorates and divisions within the Health system as well as related departments.

Under the proposed structure, the Commissioner will have the following functional heads:

Positions	*Status*
Director (Medical)	New
Director (Public Health)	Re-designation of existing post of Director (H&FWS)
Director (Procurement and Maintenance/Logistics)	Upgrading existing post of AD (GMS)
Director (SIHFW)	Existing
Mission Director NRHM	Existing
Chief Vigilance Officer	Existing

Director of Public Health & Medical Services

Continuing the proposal for main cadres namely Public Health and Medical services, it is proposed to have a similar structure at the Directorate. Thus, the key preventive, promotive and curative functions of the Directorate of Health and Medical Services among two directors, i.e. Director – Medical (for curative & clinical services) and Director – Public Health (Preventive & promotive services). Thus will ensure equal commitment from the Directorate for both Public Health as well as Medical Further, it will provide focused supervision in each of the areas. It will also address the promotional opportunity to each cadre to be their respective Directors.

Wing	*Position*	*Present*	*Proposed*
Directorate of Medical Services	Director (Medical)	***NEW***	Director (Medical) is a new post and will be the operational head of the clinical and curative services. The D (M) is will be reported by two Additional Directors - Medical and Programs.
	Additional Director (Medical)	The AD (M) currently exists. The AD (M) will look after the Hospital and Hospital Management aspects. The	AD (M) will be assisted by the following Joint Director – Medical, who will be assisted by two Deputy Directors –

		AD (M) will be responsible to develop an efficient referral mechanism in the State to ensure speedy treatment at various levels of hospital care.	Medical (South) and Medical (North).
	Additional Director (Programs)	***NEW***	Additional Director (Programs) is a new post and has been created to bring greater emphasis and co-ordination among various health programs. This post will be assisted by three existing Joint Directors (JDs) – Tuberculosis (TB), Ophthalmology (OPH), Non-communicable Diseases (NCD). The JDs will primarily be responsible for the curative and research aspects in their specialized respective areas.
Directorate of Public Health	Director (Public Health)	***Re-designation of the post of Director (H&FW)***	D (PH) is a re-designation of the post of Director (H&FW) and will be overall in-charge of the Public Health development in the State. He/She will utilize his/her resources for effective implementation of the various National and State level public health programs. He/She will be assisted by the following Additional Directors – Karnataka State AIDS Prevention Society (KSAPS), Rehabilitation of Child Health (RCH), Primary

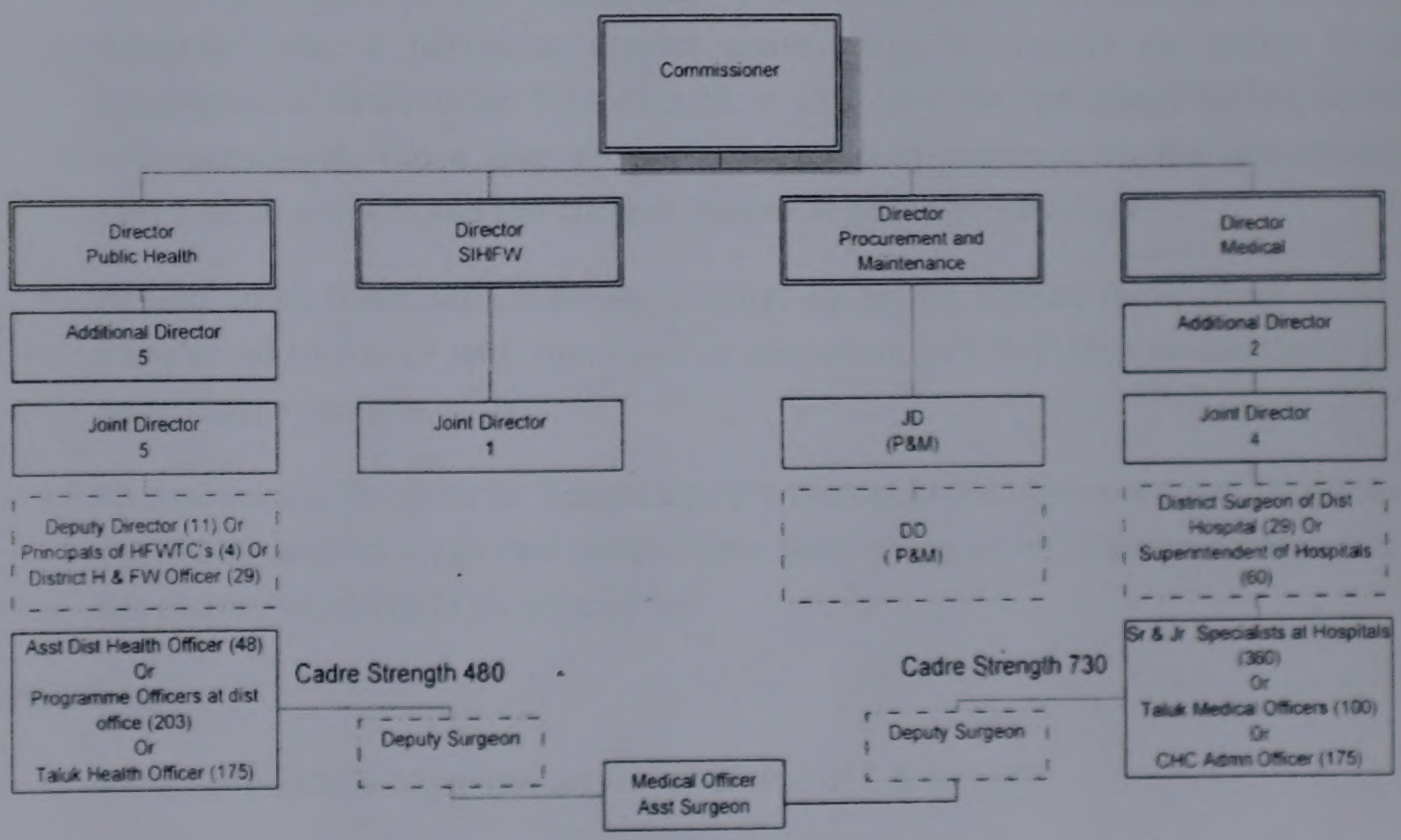
		Health Care (PHCs) and Communicable Disease Control Program (CMD).
Additional Director (KSAPS)	AD (KSAPS) is an existing post and reports directly to Project Director, KSAPS.	***Continue to perform the same***
Additional Director (RCH)	AD (RCH) is an existing post and will continue to perform the key current functions. The post will be assisted by JD (RCH), JD (IEC), Demographer and System Analyst.	***Continue to perform the same***
Additional Director (PHC)	AD (PHC) is the overall head of the PHCs in the state and look after the operational issues related to them.	AD (PHC) is assisted by a JD (Health & Planning). To assist JD it is proposed to add a DD (Medical Supplies) in addition to the three existing DDs – Planning, Nutrition and Statistics.
Additional Director (CMD)	AD (CMD) is an existing post as Project Director, Integrated Disease Surveillance Project (IDSP) and has been re-designated as AD (CMD) and will supervise the activities of various national and state programs relating to vector borne diseases (Malaria & Filaria), Leprosy as well as Vaccine Institute and the Laboratory. Each of the above functions is managed by respective Joint Directors.	***Continue to perform the same***
Director, State Institute of Health and	Director (SIHFW)	D (SIHFW) is an existing post and heads the training function of the Department	***Continue to perform the same***

Family Welfare (SIHFW)		and SIHFW, which will be an autonomous and will report functionally to the Principal Secretary of Health. The D (SIHFW) is assisted by a JD.	
Director, Procurement and Maintenance	Director (P&M)	In the existing structure, the procurement and maintenance of various equipment and civil works is distributed across the various departments. It is proposed to centralize these activities by creating a separate cell reporting to the Commissioner.	In line with the recommendations of the Task Force, this post is being proposed in the new structure. This post may be created by upgrading the existing post of AD (GMS). Director will be assisted by the existing post of JD (Logistics).
Human Resource Development	Additional Director ***NEW***		Under the new structure, it is proposed to introduce AD (HRD) and two DD (HRD) to take care of the human resources issues that include recruitments, training, appraisal, promotion, performance management, incentives/rewards system, transfer policy, career planning and human resources planning. AD (HRD) will head the proposed HR unit. This unit will be responsible for initiating Organization Development initiatives and HR reforms for the identified critical areas to set directions and policies for the HR initiatives, to monitor and supervise the implementation of HR

		initiatives, to work our strategy for gaining employee participation and initiate effective communication strategy for the reforms and to support recruitment of personnel at high and strategic level for supporting the reforms agenda in the Department.

Cadre Strength for both the divisions

The Human Development Mission Group, Planning Department, Government of Karnataka proposed the structure for the Proposed Department of Public Health and Medical Services. The following diagram presents the overall progression of personnel in the proposed Department of Public Health and Medical Services. It also represents the cadre strength for both the divisions – 480 personnel in Public Health and 730 personnel in Medical. As is evident, most of the restructuring is possible by rearranging the existing posts under appropriate divisions.



Source: Draft Action Plan, Human Development Mission Group, Planning Department, GoK.